

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/26/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155072</b>		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/19/2011</b>	
NAME OF PROVIDER OR SUPPLIER  <b>BEECH GROVE MEADOWS</b>				STREET ADDRESS, CITY, STATE, ZIP CODE <b>2002 ALBANY ST</b> <b>BEECH GROVE, IN 46107</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for the Investigation of Complaints IN00094540, IN00094610, and IN00094772.</p> <p>Complaint IN00094540- substantiated, no deficiencies related to the allegations are cited.</p> <p>Complaint IN00094610- substantiated, no deficiencies related to the allegations are cited.</p> <p>Complaint IN00094772- unsubstantiated, due to lack of evidence.</p> <p>Survey dates: August 17, 18, 19, 2011</p> <p>Facility number: 000029 Provider number: 155072 AIM number: 100275200</p> <p>Survey team: Joyce Hofmann, RN-TC</p> <p>Facility bed type: SNF: 18 SNF/NF: 106 Residential: 14 Total: 138</p> <p>Facility payor type: Medicare: 31 Medicaid: 72 Other: 35 Total: 138</p> <p>Sample: 3</p> <p>Beech Grove Meadows was found to be in compliance with 42 CFR Part 483, Subpart B and</p>			F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 410 IAC 16.2 in regard to the Investigation of Complaints IN00094540, IN00094610, and IN00094772.  Quality review completed on August 25, 2011 by Bev Faulkner, RN			F 000			